TRIO NORTHWEST BUSINESS FORMS, INC - SEATTLE WA

KING COUNTY MEDICAL INCIDENT REPORT FORM

Trauma Band #	Agency Name	Agency No.	Incident #

Mo.	Day	Yr.	Incident Address	City

Patient Name (Last, First, Middle Int.)	Birthdate	Age	GENDER	
			☐ M ☐ F ☐ Unk	Pt # _____ of _____

Patient Address	City & State	Phone	Patient Healthcare Provider

Medical Control Physician/Hospital

SPHERE **Hypertension** ☐ Hx ☐ Alert **Diabetes** ☐ Hx ☐ Alert **CONFIRM** ☐ Address ☐ Phone #

Time	:	:	:	:	:	:	:		Notes	
Blood Pressure	/	/	/	/	/	/	/			
Pulse Rate										
Respiratory Rate										
ECG Rhythm										
Oxygen (L/min)										
Pulse Oximetry (%)										
Glucometry (mg/dl)										
IV fluids (liters)										
DC Shock (joules)										

Home Medications ☐ None	**Allergies** ☐ None	

Narrative:

EMT Crew Names	**Paramedic crew names:**
1	1
2	2
3	3

Person Completing Form (PLEASE PRINT)

X_____

Signature of Person Completing Form

This document contains only a portion of the EMS report and does not constitute the full EMS record

ALS/BLS M08/P08

AGENCY COPY

Refusal of Medical Evaluation, Treatment and/or Transportation

"I hereby acknowledge that I have been advised by emergency medical personnel that evaluation, treatment and/or transportation are necessary for my condition. I have also been informed that I risk medical consequences if I refuse to be examined, treated and/or transported by emergency medical personnel. I hereby state my refusal to follow this advice and refuse further evaluation, treatment and/or transportation to a medical facility."

Patient's Name: _____ Date: _____

Patient's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

EMT or Paramedic Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Witness EMS Agency Affiliation or Address: _____

Instructions for EMS Personnel

1) Complete this form in ink.
2) Fill in patient's name, and the date.
3) Read the statement slowly and clearly to the patient. Ask if they understand what it says.
4) Have the patient sign on the "Patient Signature" line, or on the "Parent/Guardian" line if appropriate. If the patient or parent/guardian refuses to sign, or you are unable to obtain a signature for any other reason, simply make a note to that effect, sign the form and have it witnessed.
5) Obtain a signature from a witness (preferably someone from your agency), and note that person's EMS agency affiliation or address.

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Patient Address	City & State	Phone	Patient Healthcare Provider

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Time	:	:	:	:	:	:	:		Notes	
Blood Pressure	/	/	/	/	/	/	/			
Pulse Rate										
Respiratory Rate										
ECG Rhythm										
Oxygen (L/min)										
Pulse Oximetry (%)										
Glucometry (mg/dl)										
IV fluids (liters)										
DC Shock (joules)										

Home Medications ☐ None	Allergies ☐ None	

Narrative:

EMT Crew Names	Paramedic crew names:
1	1
2	2
3	3

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EMS COPY

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Time	:	:	:	:	:	:	:	Notes
Blood Pressure	/	/	/	/	/	/	/	
Pulse Rate								
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Oxygen (L/min)								
Pulse Oximetry (%)								
Glucometry (mg/dl)								
IV fluids (liters)								
DC Shock (joules)								

This document is for Quality Review purposes only
Not for general distribution. Exempt from discovery
(RCW 43.70.510)

Home Medications ☐ None	Allergies ☐ None	

Narrative:

EMT Crew Names	Paramedic crew names:
1	1
2	2
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MEDICAL REVIEW COPY

KING COUNTY MEDICAL INCIDENT REPORT FORM

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Patient Address	City & State	Phone	Patient Healthcare Provider

Medical Control Physician/Hospital	SPHERE	Hypertension ☐ Hx ☐ Alert	Diabetes ☐ Hx ☐ Alert	CONFIRM ☐ Address ☐ Phone #

Time	:	:	:	:	:	:	:		Notes	
Blood Pressure	/	/	/	/	/	/	/			
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Narrative:

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PATIENT COPY

Cardiac Arrest Worksheet: When YOUR agency performs CPR on a patient, enter this information in your electronic system.

Cardiac Arrest Witnessed	Arrest After EMS Arrival	CPR Initiated By	AED/PAD Used	Initial Arrest Rhythm	Paramedics Ceased Resuscitation Upon Arrival
Yes No Unknown	Yes No Unknown	■ First Responder / Police ■ Fire Department (BLS) ■ Paramedic (ALS) ■ Ambulance ■ MD/ RN ■ Citizen with Dispatch Assistance ■ Citizen without Dispatch Assistance ■ CPR Not Attempted	■ Citizen - No shock ■ Citizen - Shock ■ First Responder / Police - No shock ■ First Responder / Police - Shock	■ **Sinus Rhythm** ■ **Ventricular Fibrillation** ■ Ventricular Tachycardia ■ **Asystole** ■ PEA ■ Atrial Fibrillation ■ **Other** ■ **Unknown**	Yes No Unknown

Estimated Elapsed Time (Minutes) From		Time of Return of Spontaneous Circulation		Patient Outcome
Collapse to Call	Collapse to CPR	Hour	Minutes	■ DOA ■ Expired At Scene ■ Admitted to ER ■ Expired in ER ■ Admitted to Hospital ■ Unknown

EMTs: Remember to call ROC study nurse following every cardiac arrest at 1-800-607-2926 and upload defib recording.

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Glasgow Coma Scale (GCS):

Eye Opening	Verbal Response	Motor Response
4 Spontaneously	5 Oriented	6 Obeys Commands
3 To Voice	4 Confused	5 Locates Pain
2 To Pain	3 Inappropriate Words	4 Withdraws from Pain
1 No Response	2 Incomprehensible	3 Flexion to Pain
	1 No Response	2 Extension to Pain
		1 No Response